

# PATIENT REGISTRATION

**PATIENT INFORMATION** (Please list all names and nicknames) Today's Date: \_\_\_\_\_

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Street Address: \_\_\_\_\_ Apt./Suite No. \_\_\_\_\_ P.O. Box \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Facebook name/Twitter Handle \_\_\_\_\_ **May we, or our authorized agents, leave a message or contact you electronically regarding your care, scheduling, follow-up, and billing?**  Yes  No Initial \_\_\_\_\_ **If no, which number may we, or our authorized agents, utilize regarding payment?** (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Single  Married  Divorced  Widowed Employment:  Full-Time  Part-Time  Unemployed

Employer Name and Position with company: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

If applicable, please list spouse: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Is this an on-the-job or WORK-RELATED injury?**  Yes  No If yes, complete the following:

Date of Injury: \_\_\_\_\_ Worker's Compensation Claim #: \_\_\_\_\_

Name of Attorney: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**Is today's visit the result of injuries sustained in a MOTOR VEHICLE ACCIDENT?**  Yes  No If yes, complete the following:

Date of Injury: \_\_\_\_\_ Insurance Company: \_\_\_\_\_ Claim #: \_\_\_\_\_

Name of Attorney: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

**GUARANTOR INFORMATION:** (List person **RESPONSIBLE FOR BILL IF OTHER THAN PATIENT**– Please list all names and aliases) - **GUARANTOR MUST BE PRESENT**

If over 18 years of age, please indicate if billing statements should be mailed to responsible party:  Yes  No Initial \_\_\_\_\_

Relationship of Guarantor to Patient:  Self  Spouse  Parent  Other

Last Name: \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial: \_\_\_\_\_

Mailing Address: \_\_\_\_\_ Apt./Suite No. \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Work: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_ Email Address: \_\_\_\_\_

Sex:  Male  Female Marital Status:  Single  Married  Divorced  Widowed

Employer Name, Position, Address \_\_\_\_\_

**INSURANCE INFORMATION: MUST PROVIDE INSURANCE CARDS TO RECEPTIONIST TO PHOTOCOPY**

**IF SOMEONE OTHER THAN PATIENT IS THE POLICY HOLDER, PLEASE INCLUDE POLICY HOLDER'S DATE OF BIRTH**

**PRIMARY INSURANCE:** \_\_\_\_\_ Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name (Last name first): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_

**SECONDARY INSURANCE:** \_\_\_\_\_ Policy ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Policy Holder's Name (Last name first): \_\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security #: \_\_\_\_\_

**REFERRAL INFORMATION:** Were you referred by a physician?  Yes  No If yes, Name of Physician and phone # \_\_\_\_\_

How did you hear about us? Physician  Insurance  Company  Employer  Attorney  Friend  Website  Internet  Drive-by  Print Ad  Other \_\_\_\_\_

I certify that the information provided is correct to the best of my knowledge. I will not hold Mohammed Ahmad, MD, it's health providers, or it's employees responsible for any errors or omissions that I may have made in completing the information on this form.

Ø \_\_\_\_\_ Date: \_\_\_\_\_